EDMUND G. BROWN JR.
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
STERLING A. SMITH
Deputy Attorney General
State Bar No. 84287
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-0378
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CLAIRE ANN HATTENDORF,** **a.k.a. CLAIRE ANN NADOLNY,** **a.k.a. CLARE ANN HARGIS** **24095 Lama** **P.O. Box 1143** **Miwuk Village, CA 95346** **Registered Nurse License No. 364943** Respondent.	Case No. 2010-372 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1983, the Board issued Registered Nurse License Number 364943 to Claire Ann Hattendorf, also known as Claire Ann Nadolny and Clare Ann Hargis ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2011, unless renewed.

///

///

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license . . .
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

///

///

7. Code section 2770.11 states:

(a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by a committee. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

8. Code section 4060 states, in pertinent part:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 . . .

9. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

10. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

COST RECOVERY

11. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

///

///

CONTROLLED SUBSTANCES AT ISSUE

12. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

13. "Morphine sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

14. "Adderall", an amphetamine indicated for the treatment of Attention Deficit Hyperactivity Disorder and narcolepsy, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (d)(1).

RESPONDENT'S TERMINATION FROM BOARD'S DIVERSION PROGRAM AS A PUBLIC SAFETY RISK

15. On or about July 13, 2007, Respondent was enrolled in the Board's Diversion Program. On April 24, 2008, the Diversion Evaluation Committee ("DEC") terminated Respondent from the Diversion Program as a public safety risk due to Respondent's continued use of controlled substances and inability to maintain her sobriety. The DEC determined that Respondent had relapsed on March 10, 2008, April 3, 2008, and April 11, 2008, in that she tested positive for various controlled substances, alcohol, and unapproved over-the-counter (OTC) medications, as set forth in paragraph 17 below.

FIRST CAUSE FOR DISCIPLINE

(Diversion, Possession, and Self-Administration of Controlled Substances)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that Respondent did the following:

Diversion of Controlled Substances:

a. In or about May 2007, while on duty as a registered at Mercy Medical Center Merced ("MMCM"), Merced, California, Respondent obtained the controlled substances Dilaudid and

///

///

///

morphine by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows:

1. On or about May 2, 2007, Respondent removed various quantities of Dilaudid from MMCM's Omnicell system (a computerized medication dispensing system; hereinafter "Omnicell") for Patient 1 when there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's Medication Administration Record ("MAR") or document the wastage of the Dilaudid in the Omnicell.

2. On or about May 3, 2007, Respondent removed various quantities of morphine sulfate from the Omnicell for Patient 2 (the patient's physician had ordered morphine sulfate 2 to 8 mgs as needed for pain every 2 hours). Respondent charted on the patient's MAR that she administered the medication to the patient, but failed to specify the dose given to the patient or document the wastage of any portion of the morphine sulfate in the Omnicell. Further, in one instance, Respondent removed morphine sulfate from the Omnicell before the next dose of the medication was to be given to the patient, and failed to chart the administration of the morphine sulfate on the patient's MAR or document the wastage of the medication in the Omnicell.

3. On or about May 3, 2007, at 15:38 hours, Respondent removed a 2 mg syringe of Dilaudid from the Omnicell for Patient 3. At 1603 hours, Respondent wrote on the Physician's Order Form that the physician had issued a telephone/verbal order for Dilaudid 2 mg for the patient. In fact, the physician had not ordered Dilaudid for the patient.

Possession of Controlled Substances:

b. In or about May 2007, Respondent possessed various quantities of the controlled substances Dilaudid and morphine, as set forth in subparagraph (a) above, without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

///

///

///

Self-Administration of Controlled Substances:

c. In or about May 2007, Respondent self-administered various quantities of the controlled substances Dilaudid and morphine without lawful authority therefor, as set forth in paragraph 17 below.

d. On or about March 10, 2008, while enrolled in the Board's Diversion Program, Respondent self-administered morphine without lawful authority therefor, as set forth in paragraph 17 below.

SECOND CAUSE FOR DISCIPLINE

(Use of Controlled Substances and Alcoholic Beverages to an Extent or in a Manner Dangerous or Injurious to Oneself or Others)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (b), in that Respondent used the controlled substances Dilaudid, morphine, and amphetamine and consumed alcoholic beverages to an extent or in a manner dangerous or injurious to herself and/or others, as follows: In or about December 2006, Respondent began diverting Dilaudid and morphine from MMCM for self-use intramuscularly after she ran out of her prescription Norco. Respondent resigned from her position at MMCM after being confronted for narcotic discrepancies. On or about July 13, 2007, Respondent was enrolled in the Board's Diversion Program. Respondent agreed to comply with the rules and regulations of the Diversion Program as administered by MAXIMUS, including submitting to the collection of random body fluid samples for analysis and abstaining from the use of certain OTC drugs, alcohol, and all other mind altering drugs, except as prescribed by a physician. On February 19, 2008, Respondent tested positive for alcohol, amphetamines, and phenylpropanolamine[1]. Respondent told the staff at MAXIMUS that she had taken a cold preparation that had Sudafed and alcohol with phenylpropanolamine as ingredients, and that she "thought it was OK because it was OTC."

[1] Phenylpropanolamine, also known as norephedrine and oxyamphetamine, is commonly used as a stimulant, decongestant, and anorectic agent. Phenylpropanolamine is available by prescription and over-the counter as a cough and cold preparation. "Accutrim" and "Dexatrim" are trade names for phenylpropanolamine.

Respondent was warned that further use of mind-altering substances without prior MAXIMUS approval would be considered a relapse. On or about February 28, 2008, Respondent was issued a prescription for Adderall. Respondent was informed that the medication was not approved by the Diversion Program. Respondent agreed to call her primary care provider and request Strattera.[2] On March 10, 2008, Respondent submitted a urine sample for analysis and tested positive for alcohol, amphetamines, morphine, and phenylpropanolamine. On April 3, 2008, Respondent tested positive for amphetamines and phenylpropanolamine. On April 11, 2008, Respondent tested positive for alcohol and amphetamines. On April 24, 2008, Respondent was terminated from the Diversion Program as a public safety risk, as set forth in paragraph 15 above.

THIRD CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

18. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about May 2007, while on duty as a registered at MMCM, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Dilaudid and morphine, as follows:

Patient 1:

a. On May 2, 2007, at 0805 hours, Respondent removed a 2 mg syringe of Dilaudid from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the 2 mg syringe of Dilaudid.

b. On May 2, 2007, at 1125 hours, Respondent removed a 2 mg syringe of Dilaudid from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid

[2] Strattera (atomoxetine HCL) is a selective norepinephrine reuptake inhibitor used in the treatment of Attention-Deficit/Hyperactivity Disorder.

on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the 2 mg syringe of Dilaudid.

c. On May 2, 2007, at 1511 hours, Respondent removed a 2 mg syringe of Dilaudid from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the 2 mg syringe of Dilaudid.

Patient 2:

d. On May 3, 2007, at 0732 hours, Respondent removed a 10 mg syringe of morphine sulfate from the Omnicell for the patient. Respondent charted on the patient's MAR that she administered morphine sulfate to the patient at 0800 hours, but failed to specify the dose given to the patient, failed to document the wastage of any portion of the morphine sulfate in the Omnicell, and otherwise account for the disposition of the 10 mg syringe of morphine sulfate.

e. On May 3, 2007, at 0829 hours, Respondent removed a 10 mg syringe of morphine sulfate from the Omnicell for the patient. In fact, the physician's order called for the administration of morphine sulfate 2 to 8 mgs as needed for pain *every 2 hours,* and Respondent charted that she had given the patient the medication at 0800 hours (a half hour earlier), as set forth in subparagraph (d) above. Further, Respondent failed to chart the administration of the morphine sulfate on the patient's MAR, failed to document the wastage of any portion of the morphine sulfate in the Omnicell, and otherwise account for the disposition of the 10 mg syringe of morphine sulfate.

f. On May 3, 2007, at 0957 hours, Respondent removed a 10 mg syringe of morphine sulfate from the Omnicell for the patient. Respondent charted on the patient's MAR that she administered morphine sulfate to the patient at 1000 hours, but failed to specify the dose given to the patient, failed to document the wastage of any portion of the morphine sulfate in the Omnicell, and otherwise account for the disposition of the 10 mg syringe of morphine sulfate.

g. On May 3, 2007, at 1318 hours, Respondent removed a 10 mg syringe of morphine sulfate from the Omnicell for the patient. Respondent charted on the patient's MAR that she

administered morphine sulfate to the patient at 1330 hours, but failed to specify the dose given to the patient, failed to document the wastage of any portion of the morphine sulfate in the Omnicell, and otherwise account for the disposition of the 10 mg syringe of morphine sulfate.

Patient 3:

h. On May 3, 2007, at 1538 hours, Respondent removed a 2 mg syringe of Dilaudid from the Omnicell for the patient. At 1603 hours, Respondent wrote on the Physician's Order Form that the physician had issued a telephone/verbal order for Dilaudid 2 mg for the patient. In fact, the physician had not ordered Dilaudid for the patient.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 364943, issued to Claire Ann Hattendorf, also known as Claire Ann Nadolny and Clare Ann Hargis;

2. Ordering Claire Ann Hattendorf, also known as Claire Ann Nadolny and Clare Ann Hargis, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/4/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010100040
accusation.rtf